



Wakefield Country Day School  
 P.O. Box 739 Flint Hill Virginia 22627  
 (540) 635-8555 / FAX (540) 636-1501  
**Athletic Participation Physical Form**  
**2011-2012**

Name of Student (please print) \_\_\_\_\_

Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Significant Past Illness or Injury: \_\_\_\_\_

Eyes: R 20/\_\_\_\_\_; L 20/\_\_\_\_\_  
 Hearing: R\_\_\_\_\_/15; L\_\_\_\_\_/15  
 Respiratory \_\_\_\_\_  
 Cardiovascular \_\_\_\_\_  
 Spleen \_\_\_\_\_ Hernia \_\_\_\_\_ Liver \_\_\_\_\_  
 Skin \_\_\_\_\_ Neurological \_\_\_\_\_ Genitalia \_\_\_\_\_  
 Complete Immunizations: Polio \_\_\_\_\_ (Date) Tetanus \_\_\_\_\_ (Date)

I certify that I have, on this date, examined this student and find him/her physically able to complete in supervised sports activities.

Date of Examination: \_\_\_\_\_ Signed: \_\_\_\_\_  
 Examining Physician

Physician's Address: \_\_\_\_\_

Physician's Telephone #: \_\_\_\_\_

**Student's Medical History**

	<u>Yes</u>	<u>No</u>
1. Has had injuries requiring medical attention?	_____	_____
2. Has had illness lasting more than one week?	_____	_____
3. Is under a physician's care now?	_____	_____
4. Takes medication now?	_____	_____
5. Wears glasses/contact lenses?	_____	_____
6. Has had surgery?	_____	_____
7. Has been a patient in a hospital?	_____	_____
8. Is there any reason why this student should not participate in all sports?	_____	_____

Please explain any "yes" answers to above questions:

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parents/Guardians: Please complete and sign all three pages. Students are not eligible to play until all forms are completed, signed and submitted to WCDS.**



**Acknowledgement of Risk and Insurance Statement**

(To be completed and signed by parent/guardian)

The undersigned is the parent or guardian of \_\_\_\_\_ and is  
(please print name)

familiar with his/her wishes to participate in \_\_\_\_\_  
(name of sports)

For Wakefield Country Day School for the 2011-2012 academic year.

I am aware that with participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another, with contact sports carrying a higher risk. The above named student has accident insurance and is insured to our satisfaction.

In addition, I am aware that participation in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved, and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

I also give my consent and approval for the above named student to receive a physical examination by a qualified, registered physician, if offered through the school.

Student's Full Name: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

Policy/ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_